Case Management Bridge Crossings

Bridging the Chasms of Case Management . . . making it a reality

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Transitions

Summer and Fall are seasons of transitions. Summer departures, Fall arrivals; program milestones and program continuances; contract transition-out plans and contract transition-in plans. This issue of Bridge Crossings highlights these transitions as they relate to the Broad-spectrum Case Management Program (BCMP).

The case management community sends congratulatory salutes to the TRICARE team members who worked extremely hard on our new contracts. We are excited to prepare plans to incorporate the new standard of case management under a medical management umbrella. Medical management (MM) applies an integrated approach to case management, disease management, and utilization management (UM). This approach provides flexibility in aligning resources for these three functions. And best of all, the BCMP fits neatly into this approach. The BCMP allows for use of the six-step case management process for management of individuals or management of populations with similar disease/conditions. UM provides a mechanism to identify potential candidates for case or disease management and a systematic way to evaluate the effectiveness of these functions on healthcare utilization. Now for the transitions!

Transition –out activities should focus on current resources for each MM function. Identify current demand and productivity of each function. Review existing documents at local and regional levels to compare and contrast current policy with new policy. Transition-in plans can then be written to 1) comply with the new contracts and anticipated DoD directives, 2) align MM assets to match the need for specific functions at the local level, and 3) establish a system to measure effectiveness of MM programs.

As local facilities prepare to write revised or new plans for case management, it is important to review a few of the milestones achieved in BCMP and provide an update on program continuances. A major yet intangible milestone of the BCMP has been awareness. Case management has become a key consideration in military medicine and discussed often in conjunction with other aspects of healthcare delivery. It is lauded as an important process to meet the needs of vulnerable beneficiaries while positively impacting healthcare costs. There is an acute awareness that case management can meet the needs of various groups who benefit from a coordinated care approach across the spectrum of health. The BCMP has written an operational plan to broaden the application of the case management process; written and adopted a uniform definition; developed an on-line educational module and toolkit; created a website and recurring column in this newsletter to communicate program activities; provided a Tri-Service forum for discussion and actionable recommendations; written functional requirements for CHCS II; and created a Tri-Service Global Directory of case managers. and recommended adoption of national Standards of Practice for individuals and organizations.

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Program continuances include forthcoming publication of official guidance; adoption of a uniform MEPRS code; and revision of the CM website. Program continuances and new ideas signal the season of Transitions. While I would like to take a few more words to say thank you for the wonderful support from all Services, I'd rather use the rest of my word allowance to introduce you to the Fall arrival. Maj Lourdes Moore, NC, USAF has arrived at TMA to ensure that our Summer/Fall transition is smooth and uninterrupted for BCMP. Maj Moore is hard at work on the program continuances and will make plans to share her new ideas for the further enrichment of the BCMP.

See next page for a timely case management article by COL Daniel Cohen. . .

Clin Ops Corner

"There's lots going on in our corner of the world…and we want to tell it ALL!"

TRICARE Management Activity

The Office of the Chief Medical Officer

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Quote of the Month: *"The whole imposing edifice of modern medicine is like the celebrated tower of Pisa, slightly off balance."* Charles, The Prince of Wales

Message from the Executive Medical Director, Office of the Chief Medical Officer:

Clinical Case Management as a Vehicle for Individual Patient Advocacy:

Catastrophic complex illness is huge burden, physically and emotionally for an entire family. The hospital environment, which is clearly part of the solution, is also most certainly a large part of the problem; and this is especially the case when receiving care in a teaching hospital. A typical inpatient in such an environment can interact with upwards of 20 physicians at various levels of training, 40-60 nurses, innumerable other healthcare professionals and para-professionals and trainees within a brief timeframe. The experience is disheartening, confusing and very stressful, all of which confound the ability of the patient to confront the illness in a positive fashion. A sentiment expressed in a typical get-well card encourages the patient to hopefully develop enough strength to go home soon, when the fact of the matter is that it may require more strength to stay in the hospital, then to go home. A very strong case can be made for getting patients out of hospital and back into comfortable and safe surroundings as soon as possible, with an available net of resources provided within the home. Effective clinical case management is necessary to reach this goal, and we are not there yet; at least not consistently so.

In addition, hospitals are unsafe in many ways. Medication errors, unsafe equipment, lack of or miscommunication between healthcare professionals, increased reliance on non-RNs for bedside care, and other lurking dangers all work against the patient and are real threats to well being.

Under TNEX the contractors will provide case management when services are provided in the community but for patients whose needs are primarily MTF-focused, most case management responsibilities will fall on the shoulders of MTF staff. Case management should be viewed as one very important element of a utilization management plan for each MTF. After all, if patients can be discharged safely and securely to a comfortable home environment, then the cost of providing any necessary services in the home is more than offset by the savings related to early discharge. Discharge planning is critical for complex patients, and really should begin as soon as possible. For elective admissions the discharge plan template should be under development before admission, for urgent admissions, the discharge planning process should begin soon after admission; and the discharge planner, working with a complex illness clinical case manager to smooth the transition to the ambulatory setting, should be the standard for all patients. This is critically important because amidst all the complexities of the teaching hospital environment there is no specific and personal single patient advocate who seems to be the "go-to" person for all needs. Each specialist appropriately focuses on the special clinical needs he or she can provide but the connection between the specialists is often diffuse and nebulous. More often than not it is not clear who is actually in charge, and this becomes more apparent as discharge approaches and plans for follow-up need to be clarified. Some clinical services are better than others, but the game plan needs a lot of tuning in many instances.

Though the compassion and sensitivity expressed by nearly everyone the patient and family interact with during hospitalization is appreciated, the complexity of the patient's illness and furthermore the complexity of the environment in which the care has been provided, both interfere and encumber continuity. The hospital environment becomes a major part of the clinical problem which seems counterintuitive when it is the environment in which the healing process is supposed to begin. Thus, the discharge planner and the complex illness case manager need to fill this void. Ultimately the case manager should be the point of contact for patients dealing with a myriad of issues and needs, not just during hospitalization but well after hospitalization and into the home and outpatient settings.

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